MEDICAL BOARD OF CALIFORNIA
Licensing Program

ADDENDUM TO QUESTION #23

This form may be used to provide ACGME/RCPSC accredited postgraduate training information if you require additional space in response to question #23 on Form L1B.

Type or Print Legibly	APPLICANT INFORMATION	
NAME: Last	First	Middle

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

ADDITIONAL POSTGRADUATE TRAINING INFORMATION

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy to mm/dd/yyyy)	
			Start	
			End	
			Start	
			End	
			Start	
			End	
			Start	
			End	

SIGNATURE:_____ DATE:_____

Applicant's signature and date are required.

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